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TITLE

Routes to the Top: The Developmental Journeys of Medical, Clinical and Managerial NHS Chief Executives.

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ABSTRACT

INTRODUCTION: Leadership, and the role of a Chief Executive in healthcare organisations has never been more important. This review provides one of the first retrospective cross-sectional analyses of the developmental journeys of NHS chief executives.

METHODS: Twenty eight semi-structured qualitative interviews were conducted with medical, clinical and non-clinical NHS chief executives from the Health Service Journal's list of "Top Chief Executives" 2014-18. Through a thematic analysis of their narratives, lessons for the development of aspiring NHS chief executives emerge.

RESULTS: Few proactively sought leadership opportunities. There was a lack of an active leadership development strategy. Yet the 'seeds of leadership development' took root early. Combined with a blended approach of formal leadership development and 'on-the-job' informal leadership development, emerging NHS chief executives were exposed to multiple 'crucible moments' that helped them develop into and excel at the top of their field.

DISCUSSION: Top NHS Chief Executives' possess values and a sense of social responsibility that underpin their developmental journeys, guide their behaviour and strengthen their resilience. Capable, high quality leaders are needed from all professional backgrounds to support high quality care and much more needs to be done, particularly for medical and clinical professionals but for non-clinicians too, to maximise leadership potential within the NHS and develop a pipeline of aspiring NHS chief executives.

INTRODUCTION

Leadership is a critical factor in high performing healthcare organisations throughout the world, and the role of a Chief Executive in healthcare organisations has never been more important (Hambrick and Mason, 1984; Baker, 2008; Chambers et al., 2011). Yet within the NHS, they have a median tenure of only 3-years and there is a 7% vacancy rate (Anandaciva et al., 2018). Leadership development is therefore high on the national agenda, and while multiple reviews have explored the challenge of developing leadership within the NHS (Naylor, 2015; Rose, 2015; Smith, 2015; Kerr, 2018), we know little about who our NHS chief executives are, where they came from and how they ascended into one of the very top roles in British healthcare.

METHODS

The Health Service Journal (HSJ) produces an annual list of England's 'top 50 NHS chief executives', based on the personal example they set, their organisation's performance, and their contribution to the wider health and social care system (HSJ, 2017).

Determined by an expert judging panel, between 2014-2018, 117 chief executives have been named; 10 from a medical background, 28 from a clinical background and 79 from a managerial (non-clinical) background.

This review thematically analyses 28 semi-structured qualitative interviews, conducted between October and December 2018, with some of the highest-ranking chief executives from these lists; nine medical, eight clinical and eleven managerial (non-clinical), generating an equivalent sample size from the three predominant professional backgrounds.

It was conducted as part of an MBA dissertation at Warwick Business School, supervised under its governance, and adheres to research ethical principles (Beauchamp and Childress, 2001).

The findings of this research provide understanding of and may help to inform the development of aspiring NHS chief executives. It reveals who they are, how they became chief executives, and what we can learn from their background, experiences and reflections.

RESULTS

Sociodemographics

Of the 117 chief executives named across the five years of HSJ data, most were of white British origin, with 60% male and 40% female. However, with those from a managerial background excluded, this gender trend equalised, with 47% male (medical n=4; clinical n=4) and 53% female (medical n=5; clinical n=4).

Most chief executives were born in the 1960's, with an average date of birth of 1965; those from a clinical background were slightly older. Most of their parents came from professional backgrounds; seven chief executives had parents who were teachers and four had parents who worked in healthcare. Their educational background was split between state comprehensive schools (n=15), state grammar (n=8) and private schools (n=5), with no significant differences between the three cohorts. Almost all studied at undergraduate level or gained vocational nursing qualifications, and many studied at degree level later in their careers; 11 Chief Executives had business-related degrees, predominantly at postgraduate level, with 6 MBAs.

Career trajectories

Across the three cohorts, most stayed within one or two regions throughout their career, and there were no significant differences between sub-specialties or the type of organisation within which they developed.

Medically-trained Chief Executives: Ascending predominantly through traditional medical leadership roles, medically-trained chief executives were appointed at board level at an average age of 43 and Chief Executive at an average age of 49.

Few proactively considered a career in medical leadership and management and none envisaged that they would progress into their chief executive role. This rather naturally unfolded during a 'mid-career transition' (McGivern et al., 2015) out of their own desire for growth, or because it was right for the organisation.

"Most would see medical director as the end game, and that's what I thought, but I started to think more broadly, and how as chief executive I could really shape how services across the entire system worked. It's when you get your eyes opened like that, that you think wow there's more."

"It was never deliberate, I just started doing stuff because I could and because I could see a need. The new levels of leadership then found me, I didn't go looking for them: I was a bit of an accidental leader."

Clinically-trained Chief Executives: The majority held a nursing background. Most recognised that there were early opportunities to lead and implement change. They progressed to team, divisional and then organisational roles, reaching board level at an average age of 37, predominantly as directors of nursing or operations, and then chief executive at 45 years.

"I couldn't resist it when I was asked to be a ward sister, there was so much I wanted to change. I was accountable for quality, managing a budget, a team and from that point on I realised whatever role you're in, you need to be interested in both the clinical and the management, it's madness to separate the two."

Clinically-trained chief executives were driven to expand their careers by a desire to make a difference, sense of obligation or in response to a fortuitous opportunity.

"I've never actively looked for roles, status or seniority, I've just thought 'crikey, I could make a bigger difference here'. I was very happy being director of nursing and operations, but when the chief executive left, I thought I better do this... I felt duty bound to give it a go."

Managerially-trained (non-clinical) chief executives: Most chief executives from a non-clinical background entered the NHS or qualified from the NHS Graduate Management Training Scheme (or one of its precursors).

Their career trajectories were accelerated by a culture where they were afforded opportunities to learn, take risks, and because board level and chief executive positions had been placed in their sights from the earliest of stages in their careers, reaching these at an average age of 31 and 36 respectively.

"It was drummed into us that the best people can be a director in 5 years and a chief executive in 10."

"The managerial structure was very different back then, we had an enormous amount of responsibility and one of the features of my career has been to work with bosses who gave me a lot of opportunity to get involved, test things, experiment and encourage me if I found new ways of doing things."

Their motivations and eventual opportunity to lead, however, were remarkably similar to their medical and clinical colleagues, with individuals being inspired by senior mentors, role models and the opportunities available.

"I'd worked with some really good chief executives who were excellent role models, they encouraged me to think I could do it in the manner, style and with the values that I felt were really important. I wanted to make it a better hospital, a better place to work and a better place for patients to be treated."

First leadership role

Chief executives were asked to define their first leadership role. Many described roles where they had been clinically responsible for establishing a new project, service or organisation, or had absolute accountability.

"I learnt a lot moving from concept to going live with patients receiving care. It was undeniably something that was my idea, that I led and made work. It established my credibility as a leader and got me noticed."

"Being night sister, being responsible for the surgical unit overnight, being trusted to be in charge, that was probably one of the biggest things: it was having that responsibility, and I quite liked that."

However, as similarly found elsewhere (Ham et al., 2010; Murphy and Johnson, 2011), early influences also played a part. One of the first leadership experiences that stood out for approximately half of chief executives stemmed back to one of their early childhood experiences.

"Being a brownie sixer: we were on camp and out of the three of us I got congratulated by the brown owl for being sensible and responsible and I was really proud of that."

"Way back into my teens I found that I was being asked to do things which I didn't mind doing, organising events and things which were actually relatively complex for someone of that age."

Others recounted stories whereby they had been a head boy, head girl or prefect, sports captain, house captain, patrol leader in the boy scouts, narrators in the school play, or simply being *"one of those people who others always turned to for advice"*.

Formal leadership development

Most chief executives considered that early leadership development was useful. However, for the majority of medical and clinical CEOs, this often came much later in their careers.

“I’d done very little before I became a chief executive, it was like good old-fashioned medical training, an apprenticeship.”

Many received leadership training exclusively for senior healthcare leaders, often provided by The King’s Fund or the NHS Leadership Academy (and/or their predecessors). Chief Executives found these invaluable. It helped them develop a critical awareness and understanding of their own impact and approach to leadership, and to form a coherent work identity where they found ‘colleagueship’ and ‘legitimacy’ both through the nature of the course itself and the development of a professional network.

“It was absolutely invaluable, it provided validation for my career move, created a really good network as we all grew into those roles, and I really started reflecting about what leadership meant and how I would cope. It was really quite formative and gave me confidence to step into those bigger leadership roles”

Others undertook leadership training with senior leaders from a variety of sectors though, and similarly to chief executives who enrolled on executive master’s programmes, significant value was placed on the importance of face-to-face learning with those from outside of healthcare.

“Gaining recognition that healthcare is incredibly complex and holding your own against very bright people from different industries was really useful. You could open up a bit more and it massively boosted my confidence. Rather than feeling like a second-class citizen, it gave me reassurance about working for the NHS.”

Overall, regardless of professional background, the majority reflected that the real value of formal leadership development came in the application of this knowledge in the ‘real world’, from the practical elements of delivering for yourself, and from learning from those around you, but clearly, it is a blend that’s needed.

“I’d have been a poorer chief executive having not been on some of the courses I’ve been on. They’ve given me confidence to be the chief executive I wanted to be. It’s the jobs that make the real difference though: getting into the weeds of delivering stuff, working with clinicians and then reflecting with someone on what went right and what could have gone better.”

Informal leadership development

Few chief executives received any formal coaching or mentoring within their careers, although the majority had developed informal relationships where they were left feeling that they had been “*very fortunate to work with natural talent spotters*”. Often sparked by a mutual liking, these relationships had profound effects on the chief executives’ development, fulfilling their needs for guidance, support and affirmation.

“I’ve had various mentors but there’s been an absence of talent management, it was me driving those relationships or the individual wanting to see me progress rather than any form of systemic talent management.”

Chief Executives from all professional backgrounds were clear that these mentoring relationships could not be forced, but strongly encouraged their development due to the significant benefits on both their careers (including greater satisfaction (Fagenson, 1989)) and their psychosocial development, through interpersonal traits such as role modelling and friendship (Kober et al., 1998; Clutterbuck, 2009).

“Don’t have a coach or mentor for the sake of it, you need to develop a relationship with someone you can ring for help and support when times are tough; it’s a whole person thing. We talk through my career, the job, relationships at work, right down to whether I’m looking after myself and the family.”

Crucible moments

The ability to learn from and find meaning in challenging circumstances is a reliable indicator and predictor of leadership. Such experiences have been referred to as ‘crucible moments’ in a leader’s development (Bennis and Thomas, 2002).

Across the three cohorts, several chief executives described challenging, and often negative experiences, which contributed to their leadership development.

“I had an experience tantamount to bullying and intimidation but coming through that, using my own resolve, willingness to challenge, tenacity, and values, I developed a degree of leadership and personal strength that led to positive reflections on how I would operate as a chief executive in the future.”

Overwhelmingly, these often related to managing people, and specifically, removing colleagues at an executive and/or senior medical level when their behaviour fell outside of the

organisation's values; as one chief executive put it, *"moving on colleagues when they couldn't be who the organisation needed them to be"*.

"You want to help and support others but sometimes the fit just isn't right and you have to move people on. That's the hardest part, balancing what's right for the person, against your values of what's right for the patients and the organisation."

Many found this difficult, and while recognising the significance of these decisions, they did not always recognise the decisiveness with which they needed to be made and the consequences of failing to act swiftly.

"As chief executive people don't just notice how you behave but about the behaviours you allow in others. The hardest conversations are with people about the fact that they don't fit in the organisation and in having those conversations quick enough. It's very easy to create all sorts of rationalisations about why you shouldn't act, but you need to stand up for what's right, do those difficult things and by and large, people feel relieved when they see you taking action on something that you believe in."

Positive experiences were important 'crucible moments' too, with those from a medical and clinical background drawing on their professional values and training for this. They combined their credibility of having been on the frontline with their ability to 'speak the same language' as clinicians in order to influence them.

"Having practiced clinically was a real help: having worn the t-shirt and got the bloodstains by making difficult clinical decisions at 3am in the morning when all hell is going on around you, it helps one work with clinicians when you're in a managerial role. You can better balance the needs of the patient in front of you with the responsibility for whole groups of patients"

For many chief executives though, across all cohorts, it was relational. Their reflections exemplified the importance of role modelling and mentoring relationships as a mechanism for leadership development.

"Having good mentors who think you're worth developing has been vital, one specifically changed my role to round out my skills and when I went through that process, I realised that somebody who guides and advises you is incredibly important because I don't think I'd have seen it'."

Some chief executives struggled to identify one crucible moment. They described their leadership development as a process, with multiple factors that had impacted the way they lead, including the values of their profession.

"It's a combination between my family's values, the quality of my nurse training, and the support from people along the way who gave me a chance and took a bit of a risk on me."

While Bennis and Thomas (2002) describe that one of the most common crucibles occurs through individual victimisation, often secondary to having experienced some form of personal prejudice, this was less common. Almost without exception, the narratives emerging from chief executives about their crucible moments were underpinned by a profound sense of injustice or violation of NHS 'norms', which conflicted with their personal values to the extent that many were willing to sacrifice themselves in order for these to be preserved.

Resilience

Resilience involves being able to adapt to adverse situations while maintaining purpose and wellbeing (Sergeant and Laws-Chapman, 2012).

Across the three cohorts, chief executives spoke of the importance in having strong support networks at home, referring to their *"very long-suffering wife"*, their husband being their *"star and rock"* and their *"most amazing family"*. They also spoke about how *"you have to be a bit selfish at times to remain physically fit and mentally well"* and that you had to be *"disciplined about your work-life balance"*.

Having a strong support network has been clearly associated with resilience (Haber et al., 2007; Staten and Lawson, 2017). In addition to those outside of work though, many also spoke of the support they gained through their relationships at work and the strength that they drew from them, particularly from their executive teams, but also from the behaviour of those on the front line.

"I always surround myself with very good people and one of my mottos in life is to 'never worry about something that no-one else is worrying about', and so the minute I do, I share it with someone else so that we can worry about it together."

"I look in awe at the support front-line staff give each other. I don't have to face abuse and make life and death decisions every day. When you take that into

consideration my job is simple, it's just enabling them to do their job, and that's not that stressful is it?"

Many chief executives described how they drew on their values and their personality types to maintain their drive and resilience, or for those from a clinical background, their clinical careers.

"I do it for the very same reasons why I became a nurse back when I was three, because I wanted to help people and make them better."

"I have an innate optimism and resilience and that's really helped me when things have got tough, that self-doubt has crept in, or I've not been as effective as I wanted to be... and I guess I have my mum and dad to thank for that."

Several chief executives spoke of the importance of maintaining their internal compass and strongly defining the values that frame the goals and actions for the myriad of individuals within their organisation as a source of resilience when facing difficult decisions, especially when external stakeholders are involved.

"You can't be compromised. You always have to find ways to be anchored to the common purpose which is the needs of the people we serve over and above everything else because they put their entire trust in us."

"You need to know what your leadership is relevant to; patients, clinicians, and all the other staff. Often, we try to be relevant to politicians and regulators, but you need to stay clear on your focus, stay authentic to that and not do things that will make it difficult to the clinicians and for patients."

As one chief executive succinctly put it:

"You need to remain absolutely patient focussed, eternally optimistic, make decisions and do difficult things: to keep your health, your nerve, your confidence and you need people around you, you need a great team."

DISCUSSION

This paper provides a retrospective cross-sectional analysis of the developmental journey's within and across three cohorts of medical, clinical and non-clinical NHS chief executives. It provides a unique insight to help inform the development of aspiring healthcare leaders, and particularly, aspiring chief executives.

Across the medical, clinical and non-clinical cohorts, we found that a chief executive's uncompromising set of values and sense of social responsibility underpinned their developmental journeys, guided their behaviour and strengthened their resilience. These research findings therefore contradict the view that a values-based leadership culture is 'noticeably absent' in the NHS (Rose, 2015). Among the CEOs we interviewed, values were paramount to retaining their energy, curiosity, and confidence to overcome the adversity, which is an inevitable part of developing into and excelling as an NHS chief executive.

Precipitating the leadership development of many chief executives, there was evidence that regardless of sociodemographic and educational background, which were ubiquitous across professions, the 'seeds of (values-based) leadership development' took root during childhood and adolescents. Emerging chief executives experienced powerful crucible moments when the values learnt through parental modelling, positions of responsibility in adolescence, and in some cases, the nature of their training, were challenged. Helping to develop a sense of purpose, these experiences, and the nature of their values sheer existence, generated a natural predisposition to leadership and provided these emerging leaders (whether medical, clinical or non-clinical) with the power to overcome traditional barriers, experiment with their provisional selves, and evolve as 'willing' health care leaders (McGivern et al. 2015).

While ultimately ascending into chief executive positions, few, particularly from a medical or clinical background, described proactively seeking leadership opportunities early in their careers, even if they had developed a natural predisposition for this through earlier life experiences. They rather externalised responsibility for their leadership development to inspirational role models who had chosen to develop informal mentoring relationships with them or through opportunistic leadership experiences which they seized because they could and because they could make a difference. The importance with which they spoke about their mentors and role models having a powerful impact on their development was pervasive.

Chief executives all agreed that there was a lack of an active leadership development strategy within the NHS, and that while formal leadership development can be formative for some (providing content, networking, confidence, and a deeper understanding of self), it is insufficient in isolation. It is a blended approach of formal and informal leadership development that is needed to develop NHS chief executives.

Notably, there was also an 'inverse training law', whereby the availability of leadership training varied inversely to those with which the political drive and evidence base is focussed. While promoting medical and clinical leadership, these cohorts received little leadership training until late in their careers, whereas non-clinicians are afforded one of the best graduate management training schemes in the country. While this does not appear to affect the

performance of medical and clinical chief executives, in combination with their professional training, it does appear to delay their leadership development and narrow the pool of leadership talent.

With this limitation aside, leaders can survive and thrive within the NHS. All chief executives were exposed to the three primary conditions of vertical leadership development. There was a resounding view that leaders need to be protected by experienced mentors who facilitate a safe space to take risks, experiment and develop 'on-the-job', from the earliest stages in their careers. With this provided, whether formally or informally (as was predominantly the case), they described multiple 'crucible moments' where their leadership, and understanding of themselves as a leader, emerged through value-based challenges or developmental stretch opportunities.

The days of 'keen amateurs' should be numbered, but much more needs to be done, particularly for medical and clinical professionals but for non-clinicians too, to maximise leadership potential within the NHS and develop a pipeline of aspiring NHS chief executives.

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